MDS 2.0 Q&A Addendum, March 2001

Description: In March 2001 HCFA released an addendum to the comprehensive MDS 2.0 question and answer guide. This Q & A Document contains 49 question/response sets, based on recent questions directed to HCFA Central office concerning RAI Version 2.0. This document represents an addendum to the original MDS 2.0 question and answer guide dated October 1996 and is a adjunct to the "Long Term Care Resident Assessment User's Manual, Version 2.0" published in October 1995. This document is in Adobe (.pdf) format and has been book-marked for quick reference to questions by number and by MDS Section. This document is published by the Health Care Financing Administration (HCFA) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities.

Modification of Reason for Assessment (12/14/00)

Q: A resident was admitted to the facility under insurance coverage. An Initial Admission assessment was completed, submitted and accepted by the State. The date of admission was December 1. The Assessment Reference Date was December 8. This assessment was submitted to State on December 15. This Initial Admission assessment was not marked as a Medicare 5-day assessment. After submitting the admission assessment, the facility discovered that the insurance company would not be covering the stay after all, but the resident was eligible for Medicare Part A coverage during that time. The question is whether and how the facility may use the Initial Admission assessment that had already been submitted, as the Medicare 5-day assessment. For example, could the facility Inactivate and resubmit the assessment, adding the Medicare reason for assessment? Or could the Admission assessment be modified to add the Medicare reason for assessment?

A: Modification is not a viable option. MDS Correction Policy does not allow "Reason for Assessment" codes at MDS Items A8a or b to be modified under any circumstances. A modification request that includes changes in the reason for assessment codes will be rejected by the standard system at the State. The rationale is that, although it seems intuitive that the modification process would "work" to modify a reason for assessment in some cases, there are circumstances under which such a modification does not make sense. For example, if a Quarterly assessment were performed, it will be impossible to later "change" that assessment to a Comprehensive assessment. The pattern of assessed items is different for the two types of assessments, with a comprehensive assessment involving many items that were not assessed during the original Quarterly observation and assessment process. All of the items required on a comprehensive were not observed and assessed as of the original assessment reference date.
Similarly, in this scenario, the question is whether an Admission assessment can be modified to a PPS assessment. Here again, the pattern of observed and assessed items is different, in that Section T is required for a PPS assessment and not required for an Admission assessment, and a modification would not make sense. In the course of Correction Policy development, HCFA discussed the issue of allowing modification of reasons for assessment with stake-holders. This discussion revealed that there were cases

where a modification is inappropriate (modifying a Quarterly to comprehensive), while there were other cases (modifying a comprehensive to a Quarterly) where modification would be possible. The feedback from the industry was that it would be confusing to have a variety of rules about modification that applied, based on individual scenarios. HCFA was specifically asked by the industry to have just one, consistent rule about modification that applied all the time. Based on this feedback, Correction policy does not permit modification of reason for assessment under any circumstances. And in fact, requests for modification of reason for assessment are rejected by the standard system at the State.

Also, in the scenario referenced in the question, inactivation is not appropriate because the Admission assessment is, in fact, a valid assessment, and there is no reason to inactivate it.

Resubmission of the same assessment using a revised reason for assessment is also inappropriate unless the facility assessed all required PPS items (including Section T), AND that assessment was performed within the time frame of the Medicare 5-day assessment. If BOTH of these conditions are not met, the facility essentially missed the opportunity to comply with the requirements for the Medicare 5-day PPS assessment. The facility's remaining option is to complete a new assessment that is late, submit it and accept the default RUG rate. Retrospective assessment (assessing for a point in history) is not permissible, and Correction Policy may not be used to give the appearance of being in compliance when, in fact, the facility was not in compliance. If the facility did assess all required PPS items, including Section T within the required time frame, the facility may resubmit the assessment with the Medicare reason for assessment code and bill Medicare for the appropriate days. As a precautionary measure, facilities may opt to follow the Medicare assessment schedule in cases where they are unsure if Medicare part A will be billed.

Correction of Wrong Coding for a 30 day assessment (12/14/00)

Q: A 30-day assessment was performed within the timing requirements for Medicare 30-day assessment. However, it was incorrectly marked as a 60-day assessment. This assessment was submitted and accepted. Since both a 30-day and a 60-day are full, PPS assessments, as long as the clinical assessment is correct, does the record really need to be inactivated just because the wrong reason was coded? Can't the facility just submit a request to modify reason for assessment?

A. This is not a valid 60 day assessment. It should be inactivated and resubmitted. The facility can copy or re-key the identical assessment information, except this time using the accurate reason for assessment, and submit. The reason for assessment code may not be modified under any circumstances.

Coding MDS Items P7 (Physician Visits) and P8 (Physician Orders)

Q: Are physician visits and physician orders counted, that occurred within 14 days of the Assessment Reference Date, but prior to admission or reentry to the facility? For example, one of our residents was seen in the nursing home on 5/31 and 6/1 by 2

different physicians, and orders were written. Subsequently, on 6/3, the resident was admitted to a hospital. The resident returned to our facility on 6/7. The resident experienced a significant change in status and was newly covered under Medicare part A. We completed an assessment coded as both a Medicare 5-day and a Significant Change in Status, using 6/11 as the Assessment Reference date at MDS Item A3a. When coding Items P7 and P8, do we count the physician visits and physicians orders made on 5/31 and 6/1, since they occurred within the last 14 days? Or do we not count them, since they did not occur prior to the resident's return to the facility.

A. Both Items P7 and P8 on the MDS form include identical instructions to count what occurred "in the last 14 days (or since admission if less than 14 days in the facility)". Count physician visits and orders since the latest date of admission (the date of admission at MDS Item AB1 or date of reentry at MDS Item A4a, whichever occurred most recently). Do not count visits or orders prior to the date of admission or reentry. In your scenario, visits and orders after the time of admission or reentry on 6/7 would be counted when coding the Medicare 5-day/Significant Change assessment. The visits and orders on 5/31 and 6/1 are not counted, even though they occurred within 14 days of the Assessment Reference Date, because they are not after the most recent admission or reentry. The same consideration applies for any assessment completed after a reentry.

Other Medicare Required Assessment

Q: When do I do an "Other Medicare Required Assessment"?

A: This assessment type is performed only for those beneficiaries who remain in a Part A SNF stay after all rehabilitation therapy has been discontinued. This means that in cases where all therapy is ended, and the clinician determines that the beneficiary is not ready for discharge to home or to a lower level of care even 8-10 days later, that an Other Medicare Required Assessment (OMRA) must be performed with an assessment reference date that is the 8th, 9th or 10th day after therapy ends. The new RUG-III group to which the beneficiary classifies will be the basis for the payment rate for the days until the next scheduled assessment is due, and the next payment period begins. We expect that there will be many cases in which the beneficiary will be discharged from the facility shortly after therapy ends. In SNF practice prior to PPS, many beneficiaries are discharged to their homes immediately upon the discontinuation of rehabilitation therapies. Likewise, many SNF residents who receive rehabilitation therapy services under Medicare Part A are moved to a non-Medicare level of care following the cessation of therapy services. These same circumstances will exist when the SNF is subject to PPS.. There is no expectation that all Medicare Part A beneficiaries receiving rehabilitation services in the SNF will be assessed 8 - 10 days after those services are ended. In fact, if the beneficiary stays in the nursing home through the 8th day following therapy discontinuation, there is an expectation that there is some clinical reason for his continuing stay that will be supported by the medical record. We realize that there may be many cases in which the beneficiary stays in the SNF for a few days after therapy ends in

order for the facility staff to verify that his status is stable and to assure that the plans for his next destination are appropriate and in the best interests of the beneficiary. Routine use of 8 - 10 days for verification that the beneficiary is stable and no longer in need of skilled nursing or therapy services is not appropriate. A pattern of OMRA assessments immediately preceding discharge from the Medicare bed or from the facility would signal to us that perhaps the facility is using those 8 - 10 days in a wasteful manner. It is unfair to the beneficiary to use any of his 100 Medicare SNF benefit days unless he is in need of skilled services. Likewise, it is a waste of Medicare Trust Fund dollars to have Medicare pay for days that are not needed by the beneficiary. The beneficiary should not be kept in a Medicare Part A stay if skilled services are neither needed nor being provided. We believe that nursing homes' clinical staff know when there are no skilled services needed by a beneficiary. HCFA guidelines provided in the Provider Reimbursement Manual (Transmittal 405) reinforce the expectation that facilities may, and are expected to, act in the best interest of the beneficiary with regard to use of the beneficiary's limited SNF benefit days by ending Medicare Part A coverage appropriately.

The following are questions and answers regarding Section T of the RAI:

Q: Can a therapist do an MDS without a physician's order?

A: Therapy services must be ordered by a physician. Without more detailed information from the questioner, it is difficult to understand what the therapist would be doing in the MDS without a physician order requesting the therapist either to evaluate the beneficiary or to provide services to the beneficiary.

Q: For which patients do I need to complete Section T?

A: Section T must be completed with every MDS required for Medicare Part A patients.

Q: Which items of Section T must be done on which assessments?

A: Follow the directions on the MDS exactly. The only items that are not to be completed for each full assessment are items T1b, T1c, T1d; these items are required on Medicare 5-day AND Medicare readmission/return assessments.

Q: Should I estimate the days/minutes for the Medicare patient based on 15 days even if I expect him to be discharged earlier than that?

A: Yes. The RUG-III group to which the patient is classified is based on the minutes already received (Section P) and those expected to be provided (Section T). In order to accurately group the patient, the form must be filled out according to the directions. If the patient is discharged before the end of two weeks, the facility will bill at the RUG-III group to which he classified for only the days he stayed in the nursing home.

Q: If the patient discontinues therapy and is discharged 2 days later, how can I do the Other Medicare Required Assessment that is due 8 - 10 days after therapy is discontinued?

A: You can't. If the patient leaves the facility, you are not expected to do this assessment. The Other Medicare Required Assessment is a tool to allow the facility to accurately re-classify patients for whom therapy has been discontinued. If the person is still in a Part A stay in the facility at 8 days after therapy was discontinued, it is appropriate to re-assess the person to evaluate whether the progress made during therapy was maintained and it is the first time that an assessment can be done that the look back will not capture any rehabilitation therapy provision.

Q: Is it true that Medicare Part A patients can be assigned to RUG class RHx on the 5 day assessment if the patient has received at least 65 minutes of rehabilitation therapy over the previous 7 days, and, in the first 15 days after admission is expected to receive 520 or more minutes of rehabilitation therapy on 8 or more days? Does this principle apply for RUG classes RMx and RLx with different thresholds?

A: Yes, this is how Sections T and P work together to classify patients to those three rehabilitation sub-categories using the 5 day assessment. The thresholds for the days/minutes are part of the Pseudocode that is posted on our web site as part of the documentation of the Medicare Grouper.

Q: How do you count therapy minutes when a resident is being provided PT and OT at the same time?

A: Counting therapy minutes for recording on the MDS must be based on the patient's time spent in therapy. If the patient is receiving therapy for 30 minutes from two disciplines at the same time, there are only 30 minutes to record; the therapists must agree to split it however is accurate, usually 15 minutes each.

Q: Can a patient classify into the RUx or RVx groups based on his 5 day assessment?

A: Yes, it is possible. The only patients who will classify into either of these sub-categories are those for whom a week's worth of minutes at the Ultra-High or Very-High level have been provided and recorded in Section P by the assessment reference date of the 5 day MDS. As on all 5 day assessments, Section T must be completed, but the minutes of expected therapy recorded there will not influence the classification of the patient.

Q: Do therapy minutes provided on the day of admission count?

A: Yes, but please put the beneficiary's needs ahead of the urge to rush into treatment. The beneficiary has usually had a very tiring day by the time he reaches the SNF on his day of admission. There is no need to force a therapy session too early, there are plenty of days to capture therapy minutes.

Q: My facility will enter the PPS October 1, can I begin doing Section T for the Medicare patients that I admit beginning in September?

A: Yes, that is a great idea. You will need to complete Section T in order to accurately classify those patients that are still in Medicare Part A stays when your facility enters PPS. Having already performed Section T for those patients will greatly ease your transition into PPS. Follow the directions in Section T exactly, including the items about expected therapy, even though you are not yet being paid under the new system.
Also, we have recently conceived another strategy to ease the transition. For assessments you are doing in September, that you believe may be used as Medicare 5 day assessments during your facility's transition into PPS, code "8" (Other Medicare Required Assessment) in Section AA8b, regardless of what type of assessment, is coded in Section AA8a, even though you are not yet in the PPS. This is a method that will enable the standard system at the State and Federal levels to identify the assessment as one for which a Medicare claim may be filed and for which a RUG-III group should be assigned. (If you have any questions about the Section T Qs and As above, please contact Dana Burley.)

The 5 day Assessment for Medicare SNF PPS

This assessment is to have an assessment reference date (Item A3a) of any day 1 through 8 of the Medicare Part A stay. Days 1-5 are optimal but days 6-8 are acceptable, and for some patients will actually be more appropriate. So, assess the patient using one of these first 8 days as the date from which you are viewing the patient.
For Medicare payment, we are requiring that any assessment, including the 5 day, be "completed" within 14 days of the assessment reference date. That is, the item at R2 should be a date that is within 14 days of the date at A3a. Then the assessment must be locked" within 7 days of the date at R2b, and transmitted to the State in which the SNF operates, within 31 days. However, there are other considerations to keep in mind. The first is that there is still the clinical requirement that an Initial Admission Assessment must be "completed" by the 14^{th} day of the nursing home stay. This means that in the case of a Medicare beneficiary who is entering the nursing home for the first time: a comprehensive assessment is due to be completed by the 14th day of the nursing home stay; a 5 day assessment must have an assessment reference date of any day 1 - 8 of the nursing home stay and must be "completed" within 14 days of the assessment reference date; and a 14 day assessment is required with an assessment reference date that may be as early as day 11 of the stay and as late as day 19, since this Medicare required assessment (as well as the 30, 60, 90 day assessments) has a 5 day grace period;
Given all of these requirements during the first weeks of the SNF stay, we assume that most of the time, nursing homes will opt to use the 5 day assessment to fulfill the Initial Admission Assessment requirements. In that case, the 5 day assessment, with an assessment reference date of any day 1 through 8 of the stay, will be a comprehensive assessment and will have to be completed within 14 days of the start of the SNF stay. Following completion of the Medicare 5 day assessment/comprehensive, Initial Admission Assessment, the Medicare 14 day assessment must have an assessment

reference date (A3a) that is no later than day 19 of the stay and must be completed (R2b) in 14 days, locked in 7 days, and so forth, as with the 5 day assessment. Keep in mind that there are no grace days for completion of the Initial Admission Assessment. As always, the Initial Admission Assessment must be completed by day 14. If the 14 day Medicare assessment is also the Initial Admission Assessment, no grace days may be used.
Another factor to consider in timing completion and locking of assessments: bills only may be sent for assessments that have been locked. In some cases this means that you will want to complete and lock more quickly in order to be ready for the facility monthly billing date.

Reporting Rehabilitative Therapy Minutes On The MDS

In Section P of the MDS, the clinician records the number of days and minutes of rehabilitative therapy (PT, OT, ST) received by the individual beneficiary during the past 7 days, and in the case of the Medicare 5 day assessment, since admission to the SNF. The rehabilitative therapy time reported on the MDS is a record of the time the patient spent receiving therapy services, not a record of the therapist's time. As stated in the August 1996 publication, "Long Term Care Resident Assessment Instrument Questions and Answers", Version 2.0, the patient's "therapy time starts when he begins the first treatment activity or task and ends when he finishes with the last apparatus and the treatment is ended." Set-up time is included, as is time under the therapist's or therapy assistant's direct supervision. Whether the time spent evaluating the patient is counted depends on whether it is an initial evaluation or an evaluation performed after the course of therapy has begun. The time it takes to perform an initial evaluation and developing the treatment goals and the plan of care for the patient cannot be counted as minutes of therapy received by the patient. However, reevaluations that are performed once a therapy regimen is underway (e.g., evaluating goal achievement as part of the therapy session) may be counted as minutes of therapy received. This policy was established because we do not wish to provide an incentive to perform initial evaluations for therapy services for patients who have no need of those specialized services. However, we believe that the initial assessment is an appropriate cost of doing business. Therefore, the cost of the initial assessment is included in the payment rates.
Likewise, throughout the course of treatment, the time it takes for the therapist to perform the required documentation may not be counted as time provided to the beneficiary.
NOTE: The example for counting therapy time on page 3-170 of the Long Term Care Resident Assessment Instrument User's Manual, Version 2.0 is incorrect. CROSS OUT that example. A new example will be included in the revised version.

The Long Term Care Resident Assessment Instrument Questions and Answers Version 2.0, also clarifies how to account for therapy provided to an individual within a group setting. It states that if the group has four or fewer participants per supervising therapist (or therapy assistant) then it is appropriate to report the full time as therapy for each patient. The example used is that of a therapist working with three patients for 45 minutes

on training to return to the community. Each patient's MDS would reflect receipt of 45 minutes of therapy for this session. Although we recognize that receiving physical, occupational or speech therapy as part of a group has clinical merit in select situations, we do not believe that services received within a group setting should account for more than 25 percent of the Medicare patient's therapy regimen during his SNF stay. For this reason, no more than 25 percent of the minutes reported in Section P may be provided within a group setting. To summarize: the minutes of therapy provided by at least one supervising therapist (or therapy assistant) within a group of 4 or fewer participants, may be fully counted, provided that those minutes account for no more than 25 percent of the patient's weekly therapy as reported in section P of the MDS. The supervising therapist may not be supervising any individuals other than the 4 or fewer individuals who are in the group at the time of the therapy session. Group therapy time in excess of the 25 percent threshold cannot be counted.

In addition, all therapy services must meet each of the following criteria in order to be coded on the MDS as rehabilitative therapy:
The service must be ordered by a physician.
The therapy intervention must be based on a qualified therapist's evaluation and plan of care as documented in the resident's record.
An appropriate licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing service.

Reporting minutes of therapy in Section T is somewhat different. Section T must be completed with each Medicare PPS assessment, but in the case of a Medicare 5 day assessment, the clinician captures minutes of therapy that are anticipated for the patient during the first 15 days of his nursing home stay. This makes it possible for the patient to classify into the appropriate RUG-III rehabilitation group based on his anticipated receipt of rehabilitative therapy when the assessment is done during the first few days of the SNF stay and there has not been enough time to provide more than the beginning of a course of rehabilitative therapy. The RUG-III grouper takes into consideration both the days and minutes already received by the patient as reported in Section P and the days and minutes expected to be received in the first 15 days of the stay. The number of days and minutes expected, as reported in section T should include those already received. For example, if the patient received an hour of therapy on both the fourth and fifth days (a Monday and Tuesday) of his SNF stay and the prescribed regimen is for him to receive an hour of therapy daily, Monday through Friday, during his first 2 weeks in the SNF; 2 days and 120 minutes would be reported in Section P, and 10 days and 600 minutes would be reported in Section T. The 10 days and 600 minutes includes the 2 days and 120 minutes already received plus the upcoming 3 days and 180 minutes in the first week and the 5 days and 300 minutes of therapy in the second week. The directions for completion of Section P instruct the assessor to look back over the "last 7 calendar days," counting only post admission days and minutes of therapy, when counting the days and minutes of rehabilitation therapy administered. Seven calendar days are, by definition, consecutive days. In the case of a Medicare 5 day assessment, however, the assessor will choose as

the assessment reference date (MDS item A3a) any day 1 - 8 of the stay, and will look back over the prior 7 calendar days (or over the days since admission is the assessment reference date if earlier than day 7) and count the number of days upon which more than 15 minutes of therapy were administered, and will count the number of minutes that were provided to the individual patient during those days. It is irrelevant if there is a break in therapy for a weekend or holiday during that time. For example, if day 5 of the stay is chosen as the assessment reference date, the assessor would look back to admission to count the patient's OT, PT, and ST time. If PT was provided for 50 minutes on both the second and fifth days of the stay, that would be recorded as 2 days of PT and 100 total minutes of PT. The actual time therapy was provided should be recorded. It does NOT have to be expressed in multiples of 15 or 10.

Further clarification of Section T:

1.In order to complete the last part of Section T, item 3, Case Mix Group' put the three character code for the RUG-III group into the first 3 spaces of the 5 space Medicare casemix item and 07' into the last 2 spaces. For example, a patient who classifies into the least intensive Clinically Complex group (CA1) would be coded in item T3 (Medicare casemix) as "CA107". Instructions for completion of the State blocks will be issued to providers by their States.

2.Physical, speech and occupational therapy provided outside the building IS captured in Section T, as long as the staff providing therapy meet the qualifiers. See SOM Transmittal #272, pp. R64, "The therapy treatment may occur inside or outside the facility."

3.Pay attention to the skip instructions for item T2 is italics at the top of the item. Be sure you are using the MDS 2.0, 1/30/98 version.

4.The items at T2a-e capture information based on the same one episode when the resident walked the farthest without sitting down, regardless of the need for assistance to get to a standing position. This episode may be a time during therapy. This observation item captures the single HIGHEST level of independence in the observation period (in contrast to capturing the most assistance needed in the observation period, as in Section G of the MDS).

5.Since this most independent episode may have occurred in therapy (even if the patient was using parallel bars at the time) or on the nursing unit, the communication between therapists and nursing staff ON ALL SHIFTS is essential.

6.Section T1b of the MDS, the item in which expected therapy is reported, only may be completed for the 5 day Medicare assessment or on a Medicare readmission/return assessment (AA8b= 1 or 5).

7.If your MDS automation software (incorrectly) requires that MDS items T1b, c and d be addressed on an Initial Admission Assessment (AA8a=01), then the following work-around' can be used until the software is corrected: Enter "0" at MDS item T1b. This will allow MDS items T1c and d to be skipped. One validation error will occur indicating that T1b should be skipped. This error can be ignored until the software is corrected. Note that if this work-around is not used, the facility will receive 3 error messages (one for each MDS item T1b, c, and d).

RAP Triggers

Q. I have heard some rumors that when the SOM is released there are some changes to RAPs and/or triggers. Is this true? If so, when are vendors going to find out?

A. There are no changes to the RAP triggers. The RAP Calculation technical information that we have posted on the MDS web site is accurate. The rumor you heard about the pending State Operations Manual (SOM) revision having a change to RAP trigger information has to do with the fact that the original SOM (Transmittal #272) containing RAP information inadvertently omitted MDS Item E4eA as a Trigger for the Behavioral Symptoms RAP. We are correcting this in the revised SOM. The RAP Calculation information currently posted, and the User's Manual (page C-43), have always been correct.

Privacy Act and the Freedom of Information Act

Q: Where can I obtain a copy of the Privacy Act?

A: Copies of the Privacy Act as well as the Freedom of Information Act , are available from the Department of Justice's website, (www.usdoj.gov/foia). Note: You will be leaving the HCFA website.

The Q & A document for Version 2.0 is published by the Health Care Financing Administration (HCFA) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities.

Please note that on 2/19/97, three minor changes were made to the Q & A document. The changes made were:
Question #41 The original question beginning "How should items G1c and d," now correctly reads "How should items G1e and f," Question #43 The original question beginning "Is standing balance (MDS item G3b)"now correctly reads "Is standing balance (MDS item G3a)". Question #186 In the second sentence of the response, the original phrase beginning "but in no case less than 14 days" now correctly reads "but in no case later than 14 days".